GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2018-2019
Performance Oversight Hearing

Testimony of
Wayne Turnage
Director, Department of Health Care Finance

Before the
Council of the District of Columbia
The Honorable Vincent C. Gray, Chairperson

John A. Wilson Building
Room 412
1350 Pennsylvania Avenue, NW
Washington, DC 20004
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10:00am

Introduction

Good morning, Chairperson Gray and members of the Committee on Health. My name is Wayne Turnage, and I am the Director of the Department of Health Care Finance (DHCF). Thank you for inviting me to testify on behalf of Mayor Bowser in today's hearing to discuss the activities and accomplishments of DHCF in Fiscal Year 2018 (FY2018) and the first quarter of Fiscal Year 2019 (FY2019).

Mayor Bowser's Fiscal Year 2018 budget made investments that supported our efforts to deliver on the promise of our shared DC values. These efforts include creating economic opportunity, making our neighborhoods safer, and providing more effective and efficient government services. We continue that effort as we work each day to fulfill our commitment to provide every District resident a fair shot at opportunity.

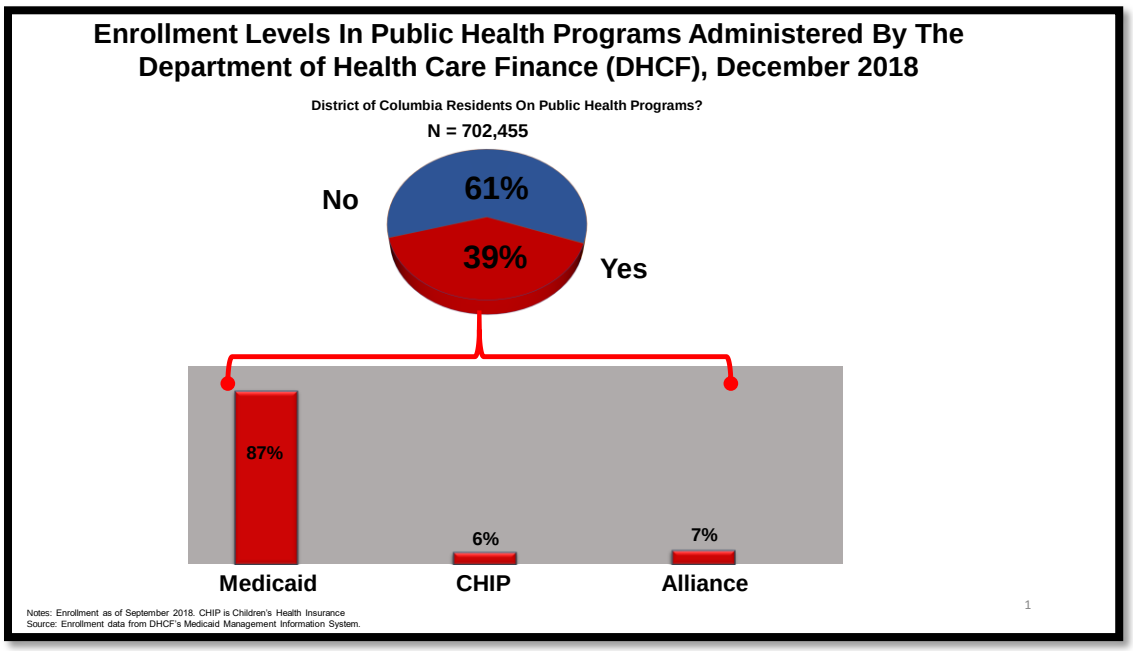
As we enter Mayor Bowser's second term, the agencies under her charge have been directed to continue the successful policies and programs of her first term while developing strategies for the next four years that build on these successes. One of her key goals centers on improving health outcomes and closing access gaps across the District. Accordingly, my testimony today will summarize some of the activities of DHCF over the past 16 months, as well as provide a roadmap to our plans for the agency in concert with this goal as we approach FY2020.

For the past five months, I have been serving in a dual role, balancing the responsibilities of the Director of DHCF with those of Interim Deputy Mayor for Health and Human Services (DMHHS). These are weighty responsibilities, and I would not have been able to manage the many duties of these two roles without the very capable executive team from DHCF—all of whom are here with me today; the Chief of Staff of the Deputy Mayor's office,

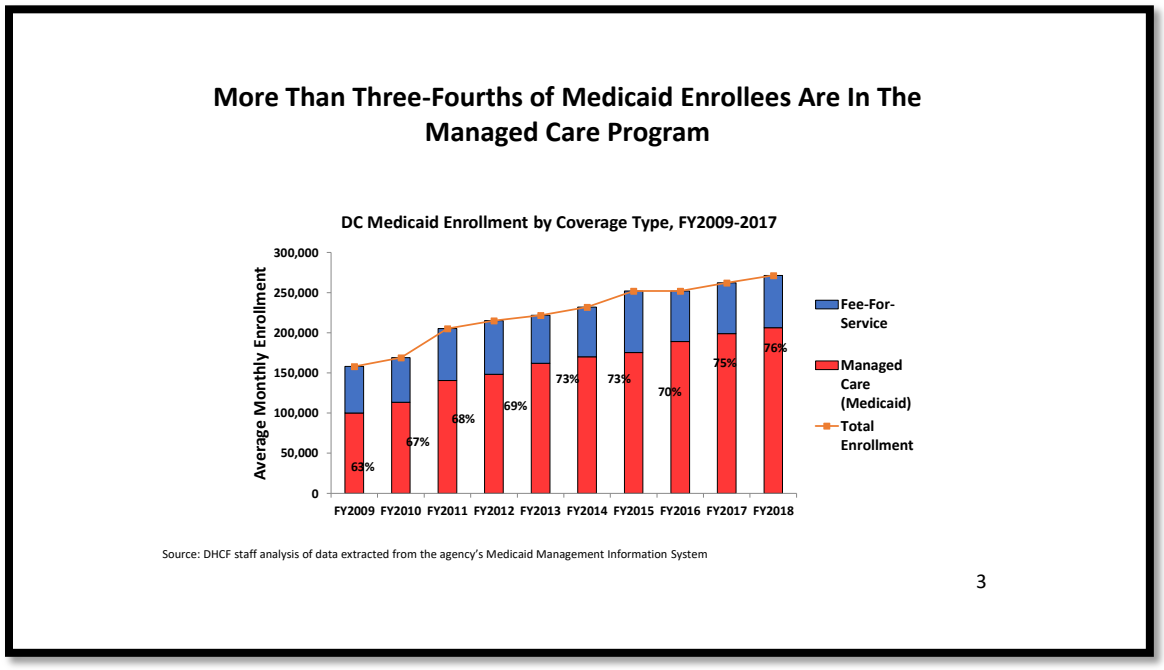
Jay Melder; and the impressive staff who handle the day-to-day operations at both agencies. Our goal is to work very closely with the Executive Office of the Mayor each day to advance both policies and programs that promote access to quality health care across all neighborhoods of the District of Columbia.

Agency Mission and Challenges

Since its formation in October 2008, DHCF's mission has remained unchanged: improve health outcomes by funding access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia. We do this through the administration of two primary insurance programs — Medicaid and Alliance — in addition to the Children's Health Insurance Program (CHIP) and the Immigrant Children's Program (see graph below). As of September 2018, we fully financed the health care cost for 271,462 individuals. This represents 39 percent of all District residents, 87 percent of whom are enrolled in Medicaid, with the remaining 13 percent receiving benefits from CHIP (6 percent) and Alliance (7 percent).



DHCF currently operates a bifurcated program in which roughly three-quarters of our members receive care through the Medicaid managed care programs, while the remaining 24 percent receive care through the District's fee-for-service (FFS) Medicaid program. Since 2009, DHCF has increased the proportion of its Medicaid enrollees in managed care by 20 percent, from 63 to 76 percent (see graph below). Enrollment in managed care often results in improved care coordination, better utilization of preventative healthcare services, and positive health outcomes.



Outside of managed care, and as a part of its FFS program, DHCF funds a series of long-term care support services for some of the District's most vulnerable residents. As with other State Medicaid programs, the District provides long-term care services in institutional, home, and community-based settings. As currently organized, long-term care services account for nearly one-third of the dollars we spend on Medicaid in the District of Columbia. These funds

are used to purchase nursing home services for persons who need this level of institutional care, a full range of home and community-based services for members who require assistance to live in the community, and a mix of support services that are delivered in both institutional and community-based programs for persons with profound intellectual, developmental, or physical disabilities. The number of beneficiaries and the associated per-member cost for each of the programs in FY2018 are shown below.

Medicaid Institutional And Waiver Spending, FY2018

Program Service	Total Number of Recipients	Total Cost of Services	Average Cost Per Recipient
Nursing Facility	4612	$248,706,332	$53,926
EPD Waiver	3447	$94,316,205	$27,362
State Plan PCA	5664	$207,932,080	$36,711
IDD Waiver	1768	$236,330,527	$133,671
ICF/DD	314	$91,277,626	$290,693
Total	15,805	$878,562,770	$55,587

Source: Data extracted from MMIS, reflecting claims paid during FY2018

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Over the last few years, DHCF has identified significant problems across the spectrum of the agency's long-term care services, which my staff has been working diligently to address. This included replacing an unreliable assessment tool that was used to determine patient level of care needs, identifying and addressing inadequate supports in the program, maintaining the federal cost neutrality requirement for the Elderly and Persons with Disabilities waiver program, and attending to an antiquated case management system.

Focus of DHCF's FY2018 Oversight Activities

I would now like to turn to a high-level summary of a few of our most significant projects from FY2018 and report on the progress we have made during the review period. After that, I will highlight DHCF's long-term care reform efforts to address challenges we faced, and then close my testimony with a brief discussion of our immediate and significant plans to work with the Department of Behavioral Health (DBH) on developing a mental health and substance use program transformation under new federal guidelines.

Key Projects in FY2018. With respect to DHCF's FY2018 key projects, I would specifically like to draw your attention to the following items:

1. The status of DHCF's $1 billion managed care procurement;
2. Current efforts to recalibrate provider rates for four major provider groups: nursing home facilities, Federally Qualified Health Centers (FQHCs), Specialty Hospitals, and Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/IID);
3. The status of our now two-year old My Health GPS program;
4. The progress DHCF is making with the PACE program;
5. The implementation status of the telehealth grants for Ward 8; and
6. The latest details on DHCF's efforts to expand the reach of its fraud detection program.

Status of MCO Procurement. As you may recall, the District executed a procurement in 2017 to select, on a competitive basis, three full-risk health plans to deliver managed care services for the Medicaid and Alliance programs. In response to the selection of the winning bidders, MedStar Family Practice (MedStar) filed a protest with the Contract Appeals Board (Board) challenging DHCF's decision to award contracts to Amerigroup District of Columbia, Inc. (Amerigroup), AmeriHealth Caritas District of Columbia, Inc.

(AmeriHealth), and Trusted Health Plan (Trusted). In a November 30, 2017 Opinion regarding the MedStar protest, the Board found that the District violated procurement law in awarding contracts to the three managed care plans. Based on that Opinion, the Board sustained the protest of MedStar finding that the contracting officer's evaluation of the offerors' proposals in certain respects, lacked a reasonable basis, while also concluding that the contracting officer's responsibility determination for Amerigroup lacked the required foundation to support the selection.

DHCF was not ordered to terminate the contract awards. Instead, the Board instructed the District to re-evaluate and rank the offerors' proposals in accordance with District procurement law, regulations, and the terms of the request for proposals (RFP). The Board further directed the contract officer, "to the extent necessary", to terminate any existing awardees whose proposal fell short of existing standards or did not meet the RFP requirements. The Board ordered that this reevaluation to be completed by January 25, 2018.

When the District failed to comply with the Board's order, and instead requested the option to submit another round of best and final offer (BAFO) questions during the re-evaluation period, the Board sought to limit the BAFO questions to just one proposed question. However, the District's contracting officer indicated that she was "unable to make any contract awards based on the re-evaluation and that her inability to do so was unlikely to change under the Board's current direction.

Considering this declaration, the Board ordered the District to not renew or exercise the option periods of the contract awards to Amerigroup, AmeriHealth, and

Trusted; instead, instructing the District to conduct an orderly, timely, and competitive new procurement for these services.

This process is well underway, and DHCF hopes to announce the winning bidders and submit the contracts for approval no later than March 2019. DHCF expects that by April 1, 2019, we will execute a base year contract for the balance of FY2019 and issue the first of four option year contracts in FY2020, on October 1, 2019.

Rate Rebasing for Several Providers. To update the reimbursement rates for several Medicaid provider groups in the District of Columbia, DHCF must regularly execute a rate rebasing process that modifies previously established rates. This is usually done in three-year intervals and uses the audited cost reports of the relevant providers. For most all provider rebasing, we typically anticipate an upward trend in rates, which is primarily attributed to health care inflation and worker wage increases.

In FY2018, DHCF rebased the rates for three provider groups and worked closely with the provider community during the process to understand and resolve issues. The rebasing process will be completed in FY2019 for the following providers:

- Nursing Facilities: DHCF finalized the FY2013 rebasing that adjusted the rates from October 1, 2014, through January 31, 2018. The rebasing resulted in an increase in the rate because of general increases in nursing home operating costs. In February 2018, we transitioned to a prospective patient specific rate methodology that includes add-on rate adjustments for persons who need bariatric, ventilation, and behavioral care.

- Federally Qualified Health Centers (FQHCs): DHCF finalized the first rebasing under the recently established Alternative Payment (APM) methodology based on audited FY2016 cost reports. This rebasing exercise resulted in significant increases to the rates due to growth in the cost of care, especially for physicians.

- Specialty Hospitals: Hospital rebasing was successfully implemented using FY2016 cost reports. During the process, we witnessed an increase in cost of care as well.

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs): DHCF amended the State Plan Amendment (SPA) to delay the FY2018 rebasing to FY2019. This allowed for more time to work with providers on resolving outstanding issues related to FY2014 audits, which impacted the FY2014–2016 period. Presently, based on the rebasing, it appears that some of these facilities will be required, under the federal SPA language, to repay significant funds to CMS. The agency is working with providers on ways to finalize the recoupment amounts and reasonable repayment terms.

My Health GPS. On July 1, 2017, DHCF launched the My Health GPS program to expand care management for Medicaid beneficiaries with three or more chronic conditions. Interdisciplinary teams embedded in the primary care setting serve as the central point for coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services. The goal, of course, is to improve health outcomes and reduce preventable hospital admissions and Emergency Department (ED) visits. Enrolled beneficiaries have access to services such as:

- A person-centered care plan that reflects the beneficiary's unique needs, challenges, and goals;

- Support during transitions of care between providers or facilities;

- Medication reconciliation;

- Health and nutritional counselling to promote a healthy lifestyle; and

- Referrals to organizations that offer social support such as housing assistance and adult day services.

Currently, 10 primary care entities are enrolled in the program, including seven FQHCs, two hospital affiliated primary care practices, and one community primary care practice. Nearly 4,800 beneficiaries have received services under My Health GPS since

it was launched, with approximately 60 percent in the FFS program. Most beneficiaries -- approximately 3,100 -- were enrolled in the first four months of the program, largely due to a time-limited enrollment incentive payment. We refer to this group as the "baseline cohort."

DHCF recently conducted an analysis of the baseline cohort experience for 11 months pre- and post-enrollment in My Health GPS. Early results are promising, especially since it often takes a few years to demonstrate the impact of care coordination programs. The analysis shows reductions in both non-emergency ED visits for members with low acuity illnesses and avoidable inpatient admissions. Overall, the total cost of acute care for the baseline cohort only grew at one percent, largely resulting from reductions in ED use (8%) and prescription drugs (3%).

Currently, enrollment is on par with other states, at around 10 percent of all eligible beneficiaries. However, it is important to continue to grow this program to reach more beneficiaries in need of services. Recruitment, enrollment, and retention will require innovative tactics from providers and active participation by beneficiaries.

As beneficiary enrollment grows, it will also be important to grow the provider networks by recruiting new providers and expanding existing providers' teams. As providers take on larger workloads and implement changes to their workflows, it will be necessary to initiate strategies that prevent provider burnout and ensure fidelity to the care team processes.

In FY2020, we will be implementing a pay-for-performance component as DHCF sharpens the focus on improving quality through this model of care. Increased

financial accountability will also enable DHCF to implement more flexible policies that can reduce administrative burdens while incentivizing population health management.

Program for All-Inclusive Care for the Elderly (PACE). PACE is a nationally recognized model of care for elderly and frail seniors. Under the PACE model, a provider organization is responsible for managing all primary, acute, and long-term care services for program enrollees through an interdisciplinary team of health professionals based at a designated PACE site.

In exchange, PACE provider organizations receive capitated payments that are paid by Medicare and Medicaid. To qualify for PACE, an individual must be 55 years or older, require a nursing home level of care, have the capacity to live in a community setting, and reside in the program's service area.

Since the Council's passage of the 2018 legislation authorizing PACE in the District of Columbia, DHCF staff has developed a draft SPA and regulations for the program which will soon be circulated for review. DHCF's actuary, Mercer, has completed the necessary analysis to set capitation rates for the PACE program.

Due to the complexity of the procurement process and the unique nature of PACE within a procurement framework, DHCF has been collaborating with OCP since fall 2018 to plan for the RFP process. We expect to hold a rescheduled pre-solicitation conference call with interested vendors and other stakeholders in this month.

Telehealth Grants. The Fiscal Year 2018 Budget Support Act of 2017 (the Act) required DHCF to award six telehealth grants to District organizations: (A) four grants of at least $50,000 to facilitate the development and application of telehealth services to health care providers and residents located in Wards 7 and 8; and (B) two grants of at

least $75,000 to facilitate the development and application of telehealth services to homeless shelters or public housing projects.

DHCF successfully awarded all six grants. The four "A" grants for telehealth services in Wards 7 and 8 were awarded to Medical Home Development Group, Accent on Health, Unity Health Care, and The George Washington University Medical Faculty Associates. The two "B" grants for telehealth services in homeless shelters or public housing projects were awarded to Urgent Wellness and Unity Health Care.

All grants were expeditiously awarded in FY18. Within a 6-month period of performance, each grantee was able to implement the infrastructure proposed and conduct a set of pilot telehealth visits. As of September 30, 2018, the grantees had collectively conducted more than 50 telehealth visits. Each of the awardees reported that the grant funding enabled them to build infrastructure for telemedicine services that can be sustained.

Over the period of performance, DHCF led four learning collaborative meetings with the grantees to facilitate information and resource sharing. On November 8, 2018, DHCF convened more than 80 District policy makers, providers, patients, and District agency partners to learn from the experiences of the telehealth grantees and discuss opportunities to use telehealth to promote person-centered care in the District.

Some challenges must be addressed to ensure a wider application of the technology in the District. Notably, there was some difficulty scheduling visits among providers who use different electronic health records, including unaffiliated clinical sites. There were also problems with exchanging clinical data in real time to support the

care between originating and distant sites. These are issues DHCF is addressing through our Health Information Exchange projects.

DHCF will continue work with DC Health to clarify policies and provider guidance on a scope of telehealth practice (beyond telemedicine). Specifically, there is interest in expanding the District's definition of telemedicine to include remote patient monitoring and store-and-forward, which would expand the ways telemedicine can be used. Meanwhile, DHCF will competitively award one $75,000 grant to strengthen a faith-based organization's ability to deliver health services through telehealth and hopefully reduce avoidable hospitalizations and hospital readmissions in Wards 5, 7, and 8.

Program Integrity. Finally, in FY2018, we spent a considerable amount of time developing strategies to identify vulnerabilities and mitigate fraud in our personal care services programs. There remains a nationwide concern with provider and beneficiary fraud with respect to personal care, which was highlighted in a CMS whitepaper published in November 2017 entitled, "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services".

DHCF has taken numerous steps to strengthen our fraud detection efforts in the personal care program, dating back as far as FY2016. As you may recall, in FY2016 DHCF promulgated three transmittals, which: (1) clarified the responsibility of Medicaid enrolled Home Health Agencies (HHAs) to report the termination of personal care aides to DC Health, the Board of Nursing, and DHCF; (2) established a systems edit to deny all claims delivered by any personal care aide delivering more than 16 hours of service in a single day, while triggering a required investigation by the responsible HHA; and

(3) established time and activity reporting guidelines to help improve the quality of PCA documentation and more accurately account for direct care activities.

Building on these efforts, in FY2018 DHCF mandated that all personal care aides obtain a National Provider Identifier (NPI), which must be included on claims submitted for payment. Now, in addition to employing previous edits that will reject claims which do not meet established criteria, our system denies claims with incorrect NPI numbers.

Still, challenges remain. Unfortunately, those involved in fraud constantly evolve their schemes in response to our enhanced oversight and investigatory efforts. We know, for example, that some determined personal care aides have employed GPS "spoofing" applications to falsely report their locations so as to mislead those HHAs that already use electronic verification to monitor their workers. In FY2019, DHCF is required to employ an electronic verification system across the District's entire Medicaid home health care program and will need to ensure that safeguards are in place to prevent this type of false reporting in the future.

Program Reform and Continuum of Service Efforts

I would now like to discuss our work on reforming our system of long-term care, as well as the agency's plans for building a comprehensive mental health and substance use treatment programs with the assistance of DBH.

Long-Term Care Reforms. During the past 15 months, DHCF undertook a significant effort to advance the Medicaid long-term care program through three key initiatives: (1) implementing a new assessment tool; (2) adopting a new case management system; and (3) hiring a new long-term service and supports (LTSS)

assessment vendor. We believe that pursuing these combined actions will significantly advance our efforts to address long-standing problems in a system of long-term care and improve the management and integrity of the program by:

- Employing a nationally recognized, validated, and standardized assessment tool used by other states to ensure a more correct match of services with beneficiary need;
- Improving DHCF's access to patient level of care need data by fully automating the assessment process; and
- Improving case management through the full integration into one system, DC Care Connect (DCCC), the assessment tool, its functions, and associated data.

With these changes and the implementation of the new case management system, the agency gained greater insight into the care planning process, allowing staff to understand the differential support needs of beneficiaries and the services they utilize to meet those needs. Ultimately, we will be able to monitor care transitions in a way that we have never been able to since the inception of the program.

Individually, any one of these efforts is a significant undertaking. Together, they represent a foundational shift in our LTSS operations. However, DHCF determined that it was prudent to closely align the implementation of the new assessment tool and case management system while onboarding the new vendor.

Notably, our previous assessment was a homegrown tool and allowed greater assessor subjectivity, which resulted in recommendations for services that did not fall under the current scope of the program. The new tool, InterRAI (HC) assessment, which is employed in 35 countries and 12 states, vastly improves the oversight and monitoring of the assessment process and has highly validated inter-rater reliability.

Our concurrent selection of a new vendor has provided benefits as well. Long-term care staff now communicates with the new assessment vendor, Liberty Health Care (Liberty), through both weekly meetings and on an ad hoc basis to ensure identification and resolution of any process issues, quality assurance questions, and technological or system barriers. Our routine communications with the Liberty team ensures open channels for information sharing, vendor education, and problem-solving.

In addition, Liberty has implemented and maintains ongoing quality assurance processes to provide oversight of nurse assessors and assessment completion. This includes processes for ensuring assessments' internal consistency and warranting that the assessment process comports with District regulatory and federal requirements.

While we anticipated significant challenges through the implementation process, execution was further complicated by the increased volume of assessments required of the vendor before and during the transition period. Nonetheless, Liberty has completed over 3,600 assessments and developed a workplan to ensure resolution of all outstanding or aged assessments this quarter.

The implementation process began with outreach, provider training, and user acceptance testing. Further, we employed continuous quality improvement efforts, which included user ability to submit feedback directly through the new case management system which is reviewed on a biweekly basis and implemented as appropriate.

Moving Toward Waiver Compliance. As noted earlier, through our Elderly and Persons with Disabilities (EPD) waiver, DHCF provides home and community-based services to eligible individuals who are elderly or have a physical disability. One of the many requirements of the EPD Waiver is that the District must provide the care to the

eligible population in a manner that is budget neutral to the federal government. This means that the per-person cost must be less than or equal to the per-person costs for nursing facility services. While the gap between EPD Waiver costs and Nursing Home costs has narrowed from the statistics provided in last year's oversight, the concern remains that we need to address the issues to maintain the Waiver.

When DHCF first identified that the EPD Waiver had lost its cost neutrality, efforts were undertaken to examine the underlying cost drivers, determine how we might curtail cost, and ensure people still receive a complement of services that support their health needs. Data showed that the EPD population has become older and sicker, driving up the cost per person. In our last full EPD Waiver year (April 2017 through April 2018), we spent $186 million between the two programs for the EPD population. This represents an average per member, per month cost of $44,000, which represents 67 percent of the total $65,000 per member, per month cost for all services provided for Waiver participants.

Maintaining cost neutrality is necessary to ensure continued services to the over 3,000 individuals enrolled in the EPD waiver. We must also ensure that we are providing services that will assist in the care of people that meet nursing home level of care but have made the choice to age in the community. DHCF's efforts to explore other service options and amendments that will reduce cost, while still supporting the proper level of care needed, began in FY2018 and will continue throughout the remainder of this fiscal year.

Mental Health and Substance Use Service Continuum. Finally, we are in the early stages of planning a mental health and substance use disorder (SUD) waiver that

will hopefully win CMS approval, affording DHCF and DBH the opportunity to collaborate on the design and implementation of a comprehensive continuum of care for these services in the District.

Over the last year, CMS and Congress have substantially expanded options for State Medicaid programs to receive federal reimbursement for services delivered to Medicaid eligible adults in Institutes of Mental Disease (IMD). Once limited to persons under 21 years of age or over 65 years of age, federal guidance issued in November 2017 and November 2018 now allows states to apply for Section 1115 waivers that provide federal Medicaid funding for services furnished to adults with a serious mental illness (SMI), adults with opioid addiction and SUDs, or children with a serious emotional disturbance (SED). Seventeen state SUD waivers have been approved and the U.S. Department of Health and Human Services Secretary, Alex Azar, has encouraged states to apply with the promise of a speedy review.

By pursuing one of these new policies, the District can secure more comprehensive federal Medicaid funding for adult stays and for youth aged 19-20, while also improving and integrating health across the continuum of behavioral and medical health needs. In FY17, at least 2,400 Medicaid beneficiaries had SUD or mental health conditions that resulted in IMD stays, costing the District more than $8 million in locally funded payments. This resulted in missed opportunities for treatment and disaggregation of residential treatment from other community services. The need for additional residential behavioral health services is especially acute for non-waiver FFS Medicaid beneficiaries not in the IDD or EPD Waiver programs, more than half of whom have

some mental illness diagnosis with nearly one-quarter presenting with problems of drug or alcohol addiction.

A higher than District-wide average of the FFS population is also homeless, underscoring the need for a treatment option that can offer stability in a residential setting. Providing Medicaid reimbursement for these services will allow DHCF to better track and support transitions of care between IMD and other community-based services and promote better health outcomes for beneficiaries at risk.

Increasing the availability of residential services and improving coordination across DHCF, DBH, and DC Health oversight will support a number of the goals outlined in the District's Opioid Strategic Plan, "Live.Long.DC". Specifically, it supports the intention of reducing regulatory silos and barriers to care across agencies and programs that are outlined in Goal 1; more effectively engages providers and organizations to support early intervention and treatment, regardless of payer, as outlined in Goal 3; and better ensures equitable and timely access to SUD treatment and recovery services that Medicaid beneficiaries need, as outlined in Goal 5.

In short, we believe this initiative is not only consistent with the District's strategic plan but will provide an important step forward in advancing the District's cross-program opioid prevention agenda. Recall that the Council funded DHCF to explore SUD waiver options through a one-time grant fund of $200,000, to be matched at 45 percent with federal funds. DHCF has already begun work with DBH to form a team to develop the 1115 Waiver, and in the process, coordinate efforts to secure a contractor to oversee related work. The goal of course is to build a system of care that eliminates services gaps, fosters the use of patient-centered treatment and service models, and offers

a payment solution to certain providers who are delivering significant levels of mental health and substance abuse treatment with no viable payment source.

Conclusion

In closing, I'd like to thank you for your leadership and support. We appreciate the opportunity to share our accomplishments and plans for continuous improvement and look forward to continuing to work with the Committee. This concludes my presentation. My staff and I are happy to address your questions at this time.